CAB HEALTH & RECOVERY SERVICES, INC.

Treatment makes a difference. Recovery makes a life

Client Record

Substance Abuse Treatment And Prevention Services for Individuals, Families, Commentates and Business

CLIENT'S NAME: Allen, Joseph

GUIDELINES:
Please review the following guidelines that you will be expected to follow during your stay at CAB. It is the intention of the staff at CAB to assist you in your recovery efforts and we believe that these (9) guidelines are necessary in order to promote a successful outcome.

1. **Violence including verbal abuse will not be tolerated.**
2. **Using and/or supplying alcohol or drugs will be cause for an administrative discharge.**
3. **No physical and/or sexual contact during your stay.**
4. **Respect peers and staff and most of all yourself.**
5. **Dress appropriately.**
6. **Attend Groups and Meetings.**
7. **No Smoking in the Treatment Center.**
8. **Socializing in Community areas only. Clients are not allowed in other clients' rooms or on other clients' beds.**
9. **I understand the center is not responsible for personal property or belongings.**

I agree to abide with the guidelines listed above:

Joseph M Allen

Client **Date** 3/25/04

Witness **Date**

NEXT-OF-KIN (NAME): Alicia

ADDRESS:

Street **City** **State** **Zip Code**

TELEPHONE: 978 479 6192

RELATIONSHIP TO CLIENT:

In the event of a medical emergency and your transfer to an acute care facility, it is the policy of CAB Health & Recovery Services, Inc. to notify my Next-of-kin (listed above).
I agree to allow CAB Health & Recovery Services, Inc. to notify my Next-of-kin in the event of a medical emergency and transfer to an acute care facility.

Joseph M Allen

Client Signature **Date** 3/25/04

Witness Signature **Date**

CONSENT FOR TREATMENT

I, _____, give CAB Health & Recovery Services, Inc my consent for medical treatment during my stay here, including such diagnostic and therapeutic procedures as deemed necessary by agency staff. I authorize CAB to submit and process appropriate claims to my health insurance carrier, if applicable. In the event that I have no means of paying for this treatment, I understand that the Commonwealth of Mass , through the Division of Alcohol and Drug Rehabilitation, may assume my payments for service.

Signature of Patient Date Witness

I understand that my belongings may be searched at any time during my stay and that I may not be present during such search I further understand if I elect to leave the Center before the time suggested by staff, I will be doing so against medical advice, and that CAB Health & Recovery Services will not be responsible for any consequences

Signed

Witness

I acknowledge that I have truthfully reported all of my knowledge regarding my medical an psychiatric history In addition, I have also reported all information regarding any/all medications that I am currently taking, am supposed to be taking, that have been prescribed to me.

Client **Date**

Witness **Date**

CONSENT FOR TREATMENT OF A MINOR

I, _____, give CAB Health & Recovery Services Treatment Center my consent for
(Parent or Guardian)
medical treatment for _____
(Minor Patient's Name) (Relationship to Minor)
including such diagnostic and therapeutic procedures deemed necessary by agency staff.

Signature of Parent or Guardian **Signature of Minor Patient** **Date**

Print Name **Print Name** **Date**

AMA Waiver of Harm

I, _____, wish to leave CAB Health & Recovery Services' Detox Unit in Massachusetts, against medical advice I understand leaving prematurely may result in seizures, delirium, or other serious physical and emotional consequences including death I also understand that if I leave within four hours of receiving medication, the police may be notified as I would be under the influence of mind altering drugs and my judgement may be impaired I take full responsibility for the consequences of this action.

Signed

Witness **Date and Time**

CAB Health & Recovery Services

CENTER FOR SUBSTANCE ABUSE TREATMENT

CONSENT TO TREATMENT

WITH AN APPROVED NARCOTIC DRUG

(Provisions of this form may be modified to conform to any applicable state law)

NAME OF PATIENT	DRS #:	DATE
Allen Joseph		3/25/04

NAME OF PRACTITIONER EXPLAINING PROCEDURES

NAME OF MEDICAL DIRECTOR

DR. Medwid

I hereby authorize and give voluntary consent to the above named Program Medical Director and/or any appropriately authorized assistants he/she may select, to administer or prescribe the drug(s) methadone and/or buprenorphine as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures to treat my condition have been explained to me, and I understand that it will involve my taking the prescribed narcotic drug at the schedule determined by the Program Medical Director, or his/her designee, which will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that methadone and buprenorphine are narcotic drugs that can be harmful if taken without medical supervision. I further understand that methadone and buprenorphine are addictive medications and may, like other drugs used in medical practice, produce adverse results. The alternative method of treatment, the possible risks involved, and the possibilities of complications have been explained to me, but I still desire to receive methadone and/or buprenorphine due to the risk of my return to heroin or other narcotic drugs.

I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time, and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic treatment program, since the use of other drugs in conjunction with narcotic drugs prescribed by the treatment program may cause me harm.

I also understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the program Medical Director's professional judgment, it is considered advisable.

FEMALE PATIENTS OF CHILD-BEARING AGE

METHADONE PATIENTS ONLY

To the best of my knowledge, I ☐ am ☐ am not pregnant at this time.

It has been explained to me, and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking methadone, I or the unborn child may show signs of withdrawal which may adversely affect my pregnancy or the child. I shall use no other drugs without approval of the Medical Director or his authorized assistant, since these drugs, particularly as they might interact with methadone, may harm me or my unborn child. I shall inform any other physician who sees me during my present or any future pregnancy or who sees the child after birth of my current or past participation in a narcotic treatment program in order that he/she may properly care for my child and me.

I understand that for a brief period following the birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the child's physician to know of my participation in a narcotic treatment program so that he/she may provide appropriate medical treatment for the child.

All of the above possible effects of methadone have been explained to me, and I understand that at present there have not been enough studies conducted on the long term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the Medical Director or one of his/her assistants immediately if I become pregnant.

I certify that no guarantee or assurance has been made as to the results that may be obtained from narcotic addiction treatment. With full knowledge of the potential benefits and possible risks involved, I consent to narcotic treatment, since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

SIGNATURE OF PATIENT:	DATE OF BIRTH: 05/30/26	DATE:
SIGNATURE OF PARENT(S) OR GUARDIAN(S)	RELATIONSHIP	DATE: 3/25/04
SIGNATURE OF WITNESS:		DATE:

CAB Health & Recovery Services

AUTHORIZATION (CONSENT) TO OBTAIN OR RELEASE INFORMATION AND RECORDS

Client Name: Allen, Joseph	**DOB:** 5/3/78	**DRS#: (CAB use only):**

OBTAIN: I, _____(Client or Parent/Guardian, if client is a minor) authorize CAB Health and Recovery Services, Inc., by fax or mail, to ***obtain*** information including medical and/or substance abuse and/or mental health records from:

(Name and telephone number of agency/school/physician)

(Complete mailing address of agency/school/physician)

RELEASE: I, _____(Client or Parent/Guardian, if client is a minor) authorize CAB Health & Recovery Services, Inc., via U.S. mail, to ***release*** information including medical and/or substance abuse and/or mental health records to:

(Name and telephone number of agency/school/physician)

NONE

(Complete mailing address of agency/school/physician)

Please indicate the **SPECIFIC** information to be disclosed: (Please complete each category):

- Y (N) Dates of Services
- Y (N) Intake Assessment Summary (Clinical Interview)
- Y (N) Treatment Plans
- Y (N) Diagnoses
- Y (N) Progress Notes
- Y (N) Discharge Summary
- Y (N) Psychiatric Summaries/Medications
- Y N Other_____

The purpose of this release of information is:

_____Assist in Treatment Planning
_____Billing for Treatment Services Rendered
_____Other (specify): _____
_____Coordination of Treatment
_____Evaluation

PROTECTED INFORMATION

Your signature below does not pertain to the categories listed below. Information in these protected categories will **not** be recorded or released from your record without your initials in the boxes below in addition to your signature.

INITIAL ONLY THE CATEGORIES OR INFORMATION YOU WISH CAB HEALTH & RECOVERY SERVICES, INC. TO RELEASE:

____Hepatitis B Testing/Treatment	___HIV/AIDS ___HIV Testing	____Sexually Transmitted Diseases	____Hepatitis C Testing/ Treatment

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records are protected under the federal regulations governing Confidentiality in Alcohol and Drug Abuse Patients, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires within 30 days after treatment, termination, or upon receipt of payment for treatment services rendered, whichever is longer, unless other wise specified below:

(*Specification of the date, event, or condition upon which this consent expires, not to exceed one year.)*

Client Signature: Joseph M Allen	Date: 3/25/04
Witness:	Parent/Guardian:

Date Revised: 09/03, CAB Health & Recovery Services, Inc.

Reference: 4A Rights of Persons Served/Informed Consent Corporate

CAB HEALTH RECOVERY SERVICES, INC.

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Food Service Diet Requisition

Date:	3/25/04
Name:	Allen, Joseph
Room Number:	119B
Type of Diet:	Regular
Allergies:	NKA
Comments:	

Please complete this form for all persons who require a special diet or have food allergies and forward to the Food Service Department at time of admission. Every effort will be made to accommodate the request.

CAB HEALTH & RECOVERY SERVICES, INC.

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Client Rights

Programs of CAB Health & Recovery Services, Inc. respect, support, and protect the fundamental human, legal, and civil rights of each client. The programs shall strive to keep the dignity of the individual and his/her right and responsibility of choice present in all aspects of their prevention, intervention, and treatment efforts. Access to treatment shall be impartial, and free of discrimination by race, religion, sex, or ethnicity.

All CAB programs shall guarantee client freedom from physical and psychological abuse.

At a minimum, these rights shall include freedom:

1. From strip searches,
2. To have control over his/her bodily appearance as long as one's appearance does not conflict with the program's policy regarding health, hygiene and treatment plan,
3. To examine his/her clinical record by scheduling an appointment with the Treatment Center Director or designee, along with a timely response to requests for copies of the record.
4. To challenge information in his/her client record by inserting a statement of clarification,
5. To terminate treatment at any time, unless committed to treatment under M.G.L.C. 123, s. 35, or it is determined that the client is dangerous to him/herself or others,
6. From signing over his/her public assurance, food stamps or other income to the licensee except when it is part of a mutual treatment agreement signed by both the client and the licensee,
7. To be informed of his/her client rights,
8. To bathe, shower and meet personal hygiene needs in a reasonable manner at a reasonable time,
9. To have regular physical exercise, when clinically appropriate,
10. To wear his/her own clothes, unless clinically contraindicated,
11. To send and receive sealed letters. Where the licensee deems it necessary, mail shall be inspected for contraband in the presence of the client,
12. To be given regular and private use of a pay telephone,
13. To have visitors at reasonable times. Visits by the client's attorney and personal physician, shall not be limited.
14. To have all complaints regarding professional conduct and/or quality of care, whether expressed orally or in writing, addressed.
15. To fully participate in all decisions related to his/her care, and if unable to fully participate in treatment decisions, to have representation by parents, guardians, family members, or other conservators.
16. To receive accurate, easily understandable information about alternative treatment, medication and modalities, and if required, assistance to make informed health care decisions.
17. To have a choice of health care providers that are sufficient to ensure access to appropriate high quality care.
18. To have treatment without invidious regard to race, ethnicity, creed, national origin, relation, sex, sexual orientation, age or disability.
19. To have treatment in a manner sensitive to individual needs and which promotes dignity and self-respect.
20. The provision of care in the least restrictive environment, protection from the behavioral disruptions of other persons served.

CLIENT NAME:	CLIENT SIGNATURE:	DATE:
Allen, Joseph	Joseph M Allen	3/25/04

CAB HEALTH RECOVERY SERVICES, INC.

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Letter of Understanding

I, Allen, Joseph understand that CAB Treatment Centers will make every effort to provide its clients with a safe and drug free treatment environment.

I, therefore, understand that CAB Treatment Centers reserves the right to report anyone to the State or local Police Departments who distributes, possesses, uses, shares, sells, or assists in the purchase of illegal substances or drug paraphernalia on the Treatment Center property.

I understand that these are illegal activities and as such may severely limit my rights of confidentiality.

Client Signature: Joseph M Allen Date: 3/27/04

Staff Witness: Date:

CAB HEALTH RECOVERY SERVICES, INC.

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Orientation

I have received the following:

	Staff Initials and Date
• An explanation of the phone policies	
• An introduction to the staff	
• An introduction to the other milieu	
• An explanation of client rights	
• An explanation of client responsibilities	
• An explanation of the grievance procedure	
• An explanation concerning the medical protocol	
• An orientation of the fire/safety procedures	
• An orientation to the unit	
• The treatment/program schedule	
• Education of Methadone treatment for applicable clients	

Issued Linens on Admission	**Returned on Discharge**	**Staff Initials**
• 1 Pillow Case ☐	☐	_____
• 1 Bottom Sheet ☐	☐	_____
• 1 Top Sheet ☐	☐	_____
• 1 Blanket ☐ Additional ☐☐☐☐	☐	_____
• 2 Bath Towels ☐	☐	_____
2 Towels (Towels)		

Client Grievance Procedure

All clients have a right to a Grievance Procedure. Any client shall have a right to have his/her grievance heard and a decision rendered. A grievance may be brought to the head nurse or counselor. If not resolved, it will be referred to the director, who will make the final decision and so inform the client.

Witness:	Client Signature and Date:
	Joseph M Allen 3/25/04

CAB HEALTH RECOVERY SERVICES, INC.

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Acute Treatment Services-1
Admission Criteria – Level IIIA
Interim Level of Care Instrument*

Client Name: Allen, Joseph	Client #: 3398346
Date of Admission: 9/25/04	

Admission to Level III A requires meeting at least one of the specifications in Dimension 1, subsection a, b, or c.
Check all that apply.

Dimension 1: Acute alcohol and/or drug intoxication and potential withdrawal: At least one of the following:

a. The client is assessed as being at risk of severe withdrawal syndrome by:

- ☐ 1. A standardized withdrawal scale (e.g., a CIWA-A Clinical Institute Withdrawal Assessment-Alcohol) score greater than or equal to 20, or
- ☐ 2. Blood alcohol greater than 0.1 with withdrawal signs present, or blood alcohol greater than 0.3% or
- ☐ 3. Pulse greater than 110 or blood pressure higher than 160/110 and CIWA-A greater than or equal to 10 or another comparable standardized score; or
- ☐ 4. A history of seizures, hallucinations, myoclonic contractions; or
- ☐ 5. Recent (within 24 hours) serious head trauma or loss of consciousness with resultant need to observe closely; or
- ☑ 6. A history of opioid use with withdrawal symptoms that require acute nursing care for management; or
- ☑ 7. A history of daily opioid use for at least 2 weeks prior to admission and past attempts to stop at similar dosages resulted in one or more signs or symptoms of withdrawal; or
- ☐ 8. A history of daily other drug use for at least 2 weeks prior to admission and past attempts to stop have resulted in physical distress; or
- ☐ 9. A history of alcohol use with withdrawal signs and symptoms, such as elevated vital signs, diaphoresis tremors, disorientation, and gastrointestinal distress; or
- ☐ 10. The level of intoxication is of such extent that the client cannot care for him/herself or the client and public safety is comprised.

b. There is a strong likelihood the client will not complete detoxification or enter into continuing addiction treatment as evidenced by either:

- ☐ 1. A past history of detoxification at a less intensive or equal level of care without completion; or
- ☐ 2. A past history of multiple treatment attempts; or

c. This is the only available level of care which can provide the needed medical nursing support and safety for the client as evidenced by either:

- ☐ 1. The detoxification regimen or client's response to the regimen requires monitoring every two hours; or
- ☐ 2. The client requires detoxification while pregnant

Signature of Authorized Person:	Date:
N Fobbs RN	9/25/04

Check all that apply at time of admission or as manifested after admission.
Dimension 2: Biomedical Conditions and Complications: *One of the following:*

- ☐ a. Biomedical complications of addition requiring medical management and skilled care; or
- ☐ b. Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with 24-hour primary nursing interventions; or
- ☐ c. Presence of biomedical problems requiring client treatment such as
  - ☐ 1. Liver disease or problems with impending hepatic decompensation; or
  - ☐ 2. Cardiovascular disorders requiring monitoring; or
  - ☐ 3. Multiple current biomedical problems, or
- ☐ d. Recurrent or multiple seizures; or
- ☐ e. Disulfiram-alcohol reaction; or
- ☐ f. Chemical use complicating or exacerbating previously diagnosed medical conditions; or
- ☐ g. Changes in the client's medical status such as a severe worsening of a medical condition making abstinence imperative, or significant improvement in a previously unstable medical condition, allowing the client to respond to chemical dependency treatment; or
- ☐ h. Other biomedical problems requiring 24-hour observation and evaluation; or

Dimension 3: Emotional/Behavioral Conditions and Complications During Detoxification: *One of the following:*

- ☐ a. Emotional/behavioral complications of addiction requiring medical management and skilled nursing care; or
- ☐ b. Concurrent emotional/behavioral condition needing stabilization and daily medical management and primary nursing interventions; or
- ☐ c. Mental confusion/fluctuating orientation; or
- ☐ d. Co-existing serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and treatment; or
- ☐ e. Extreme depression; or
- ☐ f. Thought process impairment in abstract thinking, limitations in ability to conceptualize to the degree that the client's activities of daily living are impaired; or
- ☐ g. Alcohol and/or other drug use gravely complicates or exacerbates previously diagnosed psychiatric or emotional/behavioral condition; or
- ☐ h. Altered mental status with or without delirium as manifested by either:
  - ☐ 1. Disorientation; or
  - ☐ 2. Alcoholic hallucinosis

Signature of Authorized Person:	Date:

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Acute Treatment Services Criteria for Planned Discharge from Level IIIA or Transfer to Level IIIB or C

Client Name: Allen Joseph	Client #: 3398346	Date of Admission: 3/27/07

Criteria for Transfer to Level III B or C

Dimensional Discharge or Transfer Criteria

Check all that apply:

Dimension 1: Acute alcohol and/or other drug intoxication and/or potential withdrawal—*One of the following:*

☐ a. The client is assessed as not being intoxicated or in acute alcohol or other drug withdrawal or the symptoms have diminished sufficiently to be managed in a less intensive level of care;

☐ b. The client has protracted withdrawal symptoms which no longer require 24-hour monitoring as they are not associated with craving for the alcohol or drug and the client does not meet any of the continuing care criteria from Level IIIA;

☐ c The client meets admission criteria for a more intensive level of care.

Dimension 2: Biomedical Conditions and Complications: *One of the following:*

☐ a. The client's biomedical problems, if any, have diminished or stabilized to the extent that daily availability of 24-hour monitoring is no longer necessary.

☐ b. There is a biomedical condition that is interfering with addiction treatment and the client needs treatment in another setting.

☐ C. The client's *biomedical conditions* are stable and improving but continue to require daily nurse monitoring.

Specify the Admission Criteria numbers, checked on page 2 of this form, for Biomedical Conditions present at time of admission, that continue to require daily nurse monitoring. ☐ ☐ ☐

(Specify up to 3)

Dimension 3: Emotional/Behavioral Conditions and Complications: *One of the following:*

☐ a. The client's emotional/behavioral problems have diminished in acuity to the extent that availability of 24-hour medical, psychosocial and/or nursing monitoring on a daily basis is no longer necessary.

☐ B. A psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment and/or the safety of the treatment milieu.

☐ C. The client has *psychiatric/emotional/behavioral* conditions that are stable and improving but continue to require daily nurse monitoring.

Specify the Admission Criteria numbers, checked on page 2 of this form for Emotional/Behavioral Conditions present at time of admission, that most warrant continuing acute treatment at Level III B and Level III C. ☐ ☐ ☐

ACUTE TREATMENT SERVICES

Criteria for Planned Discharge from Level IIIA or Transfer to Level III BV and C
Interim Level of Care Instrument

For admission or transfer to either Level III B or Level III C from Level IIIA or Level IV the client must first meet the following criteria from page 3:

- 1a for Dimension 1, and
- 2c for Dimension 2, or
- 3c for Dimension 3

For admission to Level III C the client must meet at least one criteria in Steps 1 and 2 below. See Step 3 for admission to Level III B.

Criteria for admission/transfer to Level III C. *Client must meet at least one criteria under both Step 1 and Step 2.*

Check all that apply.

Step 1. Two or more admissions within the last six months to an intensive level of clinical treatment.

☐ A. The client has had two or more admissions within the last six months to Level III-B or to Level II, or

☐ B. The client has had at least one admission to a Residential Rehabilitation Program within the last six months.

Step 2. Client exhibits long term dysfunction that is documented as existing for at least one year and is documented by one or more of the following:

☐ A. Recurring job difficulties or job loss due to substance abuse, or

☐ B. Recurring social and/or interpersonal problems due to substance abuse, or

☐ C. Recurring legal encounters due to substance abuse, or

☐ D. Continued substance4 use despite a concurrent medical condition that is clearly exacerbated by the use, or

☐ E. Loss of housing as a result of substance abuse.

Comments:

Signature/Date: _____

Date of Transfer: 3.17.04

TO:

☐ Level IIIA
☐ Level IIIB
~~☒ Level IIIC~~
☒ Discharge

Signature of Authorized Person: D. Carter-Wood, CADC

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Progress Notes

Allergies: NKA

Patient's Name: Allen, Joseph

Number: ~~[illegible]~~ 3398346

Date & Time	

Patient's Name: Allen, Joseph	**Number:** 3398346
Allergies:	

Date & Time	

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Physician's Order Sheet

Patient:	Allergies:
Allen, Joseph	NKA

Date/Time	Physician Order Sheet
3/26/04 11-7	24 [illegible]
3/27/04 11-7	24 [illegible]

Date/Time	Physician Order Sheet

CAB HEALTH RECOVERY SERVICES, INC

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Vital Signs Record

☐ **Alcohol**

DATE	TIME	TEMP	PULSE	BP	RESP	CIWA
3/25/04	4PM	98°	72	130/102	16	0
3/25/04	8A		80	140/90	18	0
3/26/04	8A	97	78	128/84	16	
3/26/04	8P		76	120/78	16	
3/27/04	8A	96.8	80	110/70	16	

Name:	Age:	Allergies:	Bed #:
Allen, Joseph	25	NKA	1198

Vital Signs Record (Continued)

☐ **Alcohol**

DATE	TIME	TEMP	PULSE	BP	RESP	CIWA

Name:	Age:	Allergies:	Bed #:

CAB HEALTH & RECOVERY SERVICES INC

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Opioid Detoxification Program

Patient Name:	Allergies:	Admin. Date:
Colon, Joseph	NKA	3-25-04

Methadone Withdrawal Assessment

Give Methadone 5 mg. p o. when signs of withdrawal appear. Re-evaluate for signs and symptoms of withdrawal q 4 hrs x 24 hrs total after 1st dose: administer additional doses during this 24 hrs according to the following criteria:

- After initial assessment, 3 hours must elapse before initiating B.I.D. dosing.
- B.I.D. dosing is typically scheduled for 8 AM and 8 PM However, if signs and symptoms of withdrawal are present as noted below, and if initial assessment is completed before 2 PM, may give PRN dose of Methadone (5-10 mg) at 4 PM, as a bridging dose. You may then continue as per protocol thereafter.
- Hold any dose for sedation or mental status changes.

Pupils <5mm = 0 points >5mm = 2 points	**Bowel Sounds** Absent or decreased = 0 points <50% of time = 2 points	**Physical Signs** Rhinorrhea, Lacrimination, Agitation, Tremor, Diaphoresis, or Piloerection – 1 point each (Max 2 points)	1mm • 2mm • 3mm • 4mm • 5mm • 6mm • 7mm •
Pulse >100 = 1 point	**Dosing** Score 0-2 = no dose Score>3 give 5 mg dose (max 30 mg)	**Codes** 1. Agitation 2 Rhinorrhea/Lacrimination 3 Diaphoresis 4 Tremor 5. Piloerection	
Additional Orders *Discontinue Chlordiazepoxide 50 mg. p o qhs x 4 nocs prn for sleep if patient is assigned to dual protocol regimen, which includes the ETOH protocol			

Admission time: _____

Nursing Assessment

Date	Time	B/P	Pulse	Resp.	Pupils (mm)	Comment (See Codes)	Methadone Dose	Nursing Signature
3/25	8P	110/78	80	16	6mm	1	5	RN
3/26/04	12A	124/76	72	16	6mm	BS 1,3	5 mg	RN
3/26/04	4A	110/90	76	16	6mm	BS 1,2,3	5mg	RN
3/26/04	8A	128/84	78	16	6mm	BS 1, 3	5 mg	RN
3/26/04	12P	118/80	76	16	6mm	BS 1,2,3	5 mg	RN
3/26	4P	120/80	76	16	6mm	BS 1	Refused	RN

DETOX PROTOCOLS

Total Dose 1st 24 hours	30 mg.	25 mg.	20 mg.
2nd 24 hours give	15 mg 10 mg.	10 mg B I D	10 mg 5 mg
3rd 24 hours give	10 mg B I D	10 mg 5 mg.	5 mg B I D
4th 24 hours give	10 mg 5 mg.	5 mg B.I.D	5 mg

***B.I.D. dosing 8AM and 8PM – 3 hours must elapse before initiating B.I.D. dosing (i.e., 5PM cutoff for 8 PM B.I.D. dosing)**

M.D. Signature:	Date: 5/4/04

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Methadone Protocol

Name: Allen, Joseph	Allergies NKA
Age: 25	Bed #:

METHADONE PROTOCOL

Total dose 1st 24 hours – 30 mg

Date	Date	Date	Date	Date	Date
2nd 24 hours	3rd 24 hours	4th 24 hours	5th 24 hours	6th 24 hours	
25 mg	20 mg	15 mg	10 mg	5 mg	
15 mg / 10 mg	10 mg / 10 mg	10 mg / 5 mg	5 mg / 5 mg	5 mg	DC

Total Dose 1st 24 hours – 25 mg

Date 3-26-04	Date 3-27-04	Date 3-28-04	Date 3-29-04	Date 3-30-04
2nd 24 hours	3rd 24 hours	4th 24 hours	5th 24 hours	
20 mg	15 mg	10 mg	5 mg	
10 mg / 10 mg	10 mg / 5 mg	5 mg / 5 mg	5 mg	DC

Total Dose 1st 24 hours – 20 mg

Date	Date	Date	Date	Initials and Nursing Signature
2nd 24 hours	3rd 24 hours	4th 24 hours		SS-5 Saulenas RN
15 mg	10 mg	5 mg		
10 mg / 5 mg	5 mg / 5mg	5 mg	DC	LR L Rice

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Physician's Orders Basic

Client Name:	Allergies:	BSA #
Allen, Joseph	NKA	3398346

Basic Orders

- Regular diet as tolerated.
- Activity as tolerated
- PPD, if not done in past 12 months, unless needed for aftercare; Notify M.D. if positive. (Do not do PPD if previous history of TB or previous positive (+) PPD)
- Urine HCG if female (age < 50)
- HS medications are to be administered prior to midnight
- Discontinue Ibuprofen orders when allergy to ASA reported.

Basic Medications

- Cough drops prn-cough
- Pericolace 1 tab po prn constipation
- Sudafed 30 mg po q 6 hrs PRN-Hold for BP >160/100 or Hx
- Folic Acid 1 mg. po QD
- Multivitamin 1 po QD
- Thiamine 100 mg po/IM QD
- Acetaminophen 650 mg po q 4 hrs prn
- Ibuprofen 600 mg po q 4 hrs prn
- Trimenthobenzamide (Tigan) 250 mg po q 6 hrs prn nausea or 200 mg pr/IM prn vomiting
- MOM 30 cc. Po q hs prn constipation
- Kaopectate 30 cc po after each loose stool prn diarrhea (not to exceed 8 doses in 24 hrs)
- Alamag 30 cc po q 4 hr prn
- Tussin DM 1 tsp po q 4 hr prn cough
- Kwell lotion/shampoo (2 oz) apply X1 for peduculosis, rinse in 8-12 hours
- Albuterol MDI 2 puffs q 4-6 hrs prn (hold if pulse > 120)
- Melatonin 3 mg po q hs prn insomnia
- Benadryl 25-50 mg po q 6 hrs prn rash/itch/insomnia
- Orajel ointment tooth pain prn
- Hydrocortisone cream 1% to 2.5% BID prn
- Bentyl 20-40 mg. po q 6 hrs prn
- Quinine sulfate 260 mg q 6 hrs prn X24 hrs; then 1 hs prn leg cramps
- Chlordiazepoxide 50 mg po at HS x 4 NOCS prn – **Methadone Protocol ONLY**
- **Boston Treatment Center ONLY:**
  Nicotine Patch 21 mg topically QD prn, or Nicotine gum 0.4 mg po QID prn Nicotine withdrawal.

Vital Signs

- Pulse, BP, respiration BID (8AM/8PM) and before med dosing
- Temperature, QD (8 AM)
- BP and pulse q 4 hrs and prior to administration of all withdrawal medication
- Temp. > 100.4 must be reassessed and documented q 4 hrs until resolution.
- Contact Medical Doctor (or coverage) for the following:

  TEMP. > 101.6**; PULSE >** 150 or < 50**; RESP. >** 30 or <10
  SBP >180 or <70; **DBP** >120 or <40; **ANY APNEA** ≥ 10 seconds.

MD Signature: _____ 5/4/04

CAB HEALTH & RECOVERY SERVICES, INC

Treatment makes a difference. Recovery makes a life

Medications Sheet

DATE: 3	25	26	27	28	29	30	31			
DAY:	1	2	3	4	5	6	7	8	9	10
HCG RESULT FEMAL BELOW 50	N/A	X	X	X	X	X	X	X	X	X
PPD 0.1 ML ID – IF NO DOCUMENTED RESULT WITHIN 12 MONTHS	LFA AF	X	READ	X	X	X	X	X	X	X
MULTIVITAMINS 1 PO QD (NOT PRN)										
THIAMINE 100 MG. PO QD (NOT PRN)										
FOLIC ACID 1 MG. PO QD										
ACETAMINOPHEN 650 MG. PO Q 4 HRS PRN		PS								
ALAMAG 30 CC PO Q4 HRS PRN EPIGASTRIC DISTRESS										
TUSSIN DM OR EQUIVALENT 2 TSP. PO Q4 HRS PRN COUGH										
KAOPECTATE 30 CC PO PRN AFTER EACH LOOSE STOOL (NOT TO EXCEED 8 DOSES IN 24 HOURS)										
MOM 30 CC PO Q HS PRN CONSTIPATION (X 3 NOCS)										
TRIMETHOBENZAMIDE 200 MG. PR OR IM Q 6 HRS PRN NAUSEA/VOMITING										
TRIMETHOBENZAMIDE 250 MG. PO 6 HRS PRN NAUSEA/VOMITING										
IBUPROFEN 600 MG. PO Q 6 HRS PRN DC IF ALLERGY TO ASA		4hrs	8hr							
CHLORDIAZEPOXIDE 50 MG. PO AT HS X 4 NOCS PRN ***METHADONE PROTOCOL ONLY ONLY***	DL	10P			X	X	X	X	X	X

NURSING SIGNATURES AND INITIALS

Initials	Name	Initials	Name
		DL	
		SS	
		LR	L. Rucci

Name: Allen, Joseph	Age: 25	Allergies: NKA	Bed #: 19B

CAB HEALTH & RECOVERY SERVICES INC

Treatment makes a difference Recovery makes a life

Medications Sheet

DATE: 3	25	26	27	28	29	30	31			
DAY	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
PERICOLACE 1 GELCAP PO BID PRN CONSTIPATION	4	4 10								
SUDAFED 30MG PO Q 6 HOURS PRN HOLD FOR BP > 160/100 OR HX OF HTN										
BENEDRYL 25-50 MG Q 6 HOURS PRN RASH/ITCH/INSOMNIA	1	1								
ORAGEL OINTMENT TOOTH PAIN PRN										
HYDROCORTISONE CREAM 1% TO 2.5% BID PRN										
ALBUTEROL MDI (2) PUFFS Q 4-6 HRS PRN (HOLD IF PULSE >120)										
MELATONIN 3 MG PO Q HS PRN INSOMNIA										
BENTYL 20-40 MG PO Q 6 HRS PRN										
QUININE SULFATE 260 MG Q 6 HRS PRN X 24 HRS; THEN Q HS PRN LEG CRAMPS										
COUGH DROPS PRN-COUGH										
KWELL LOTION/SHAMPOO 2 OZ APPLY X ONE FOR PEDICULOSIS RINSE IN 8-12 HRS										
BOSTON TREATMENT CENTER ONLY: Nicotine Patch 21 mg topically QD prn, or Nicotine gum 0 4 mg po QID prn Nicotine withdrawal.										

NURSING SIGNATURES AND INITIALS

Initials	Name	Initials	Name

Name:	Age:	Allergies:	Bed #:
Allen, Joseph	25	NKA	119B

Medications Sheet (Continued)

DATE:										
DAY:	1	2	3	4	5	6	7	8	9	10

NURSING SIGNATURES AND INITIALS

Initials	Name	Initials	Name

Name:	Age:	Allergies:	Bed #:

CAB HEALTH RECOVERY SERVICES, INC.

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Confidentiality Notification of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser **unless:**

1. The patient consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. SS 290ee-3, 290ff-3 for Federal laws and 42 CFR Part 2 for Federal Regulations.)

I have read and understand the Confidentiality Notification of Alcohol and Drug Abuse Patient Records.

Witness:	Client: (Parent or Legal Guardian):
Date: 3/26/04	Date: 3/26/04

CAB HEALTH & RECOVERY SERVICES INC

LYNN
100-110 Green Street
Lynn, MA 01902
SALEM
27 Congress Street
Salem MA 01970
TEWKSBURY
HART House PO Box 477
Tewksbury, MA 01876
TEWKSBURY
Transitions PO Box 837
Tewksbury MA 01876
BEVERLY
100 Cummings Center #115A
Beverly MA 01915
BOSTON
784 Massachusetts Avenue Rear
Boston MA 02118

Treatment makes a difference Recovery makes a life

ADMINISTRATION AND DETOXIFICATION
111 Middleton Road Danvers MA 01923
Voice/TTY 978 777 2121 • MA 800.323.2224
Administration Fax 978.750.3620 • Clinical Fax 978 774 4814

The undersigned has reviewed CAB Health and Recovery's **Privacy Notification.**

If you have further questions, please contact the Director of Detox Services

Client name: printed Allen, Joseph

Client Signature Joseph M Allen

DRS #

Temporary MassHealth Card

35 CONGRESS STREET - SALEM, MA

MEC/TAO	CAT	For MassHealth eligibility questions, call
262	04	1-800-841-2900 (TTY: 1-800-497-4648 for the deaf and hard of hearing). (637)

Messages:

CAT 04: EAEDC
LIMITED SERVICES ONLY

Eligible from: 03/24/2004

Eligible through: 04/23/2004

Name/RID of Eligible Person	Age	Sex	Res	TPL
JOSEPH ALLEN 029-58-2491-3 (1) ONE PERSON ELIGIBLE	25	M	O	

Issued to:
JOSEPH ALLEN
35 CONGRESS STREET
SALEM,MA 01970

X Joseph M Allen

Please sign right away.

See back of card for more information. T 2043088